Methodology

The environmental scan results are based on perceptions gathered through seven (7) targeted focus groups and nine individual telephone interviews during August-September 2005. All focus groups and interviews were conducted by Regina Podhorin from **The Leadership Group**; a Trenton based consulting firm specializing in strategic planning, nonprofit governance and program evaluation. A total of 98 individuals participated in the environmental scan process.

The focus groups covered the following stakeholder groups with a total of 89 participants:
- Current and potential providers of service (including local health departments)
- High school youth
- Medical professionals (including nurses, doctors and a dentist)
- Hospital and treatment professionals (including mental health and addictions)
- Education professionals (college level personnel)

Individual phone interviews were conducted in situations when the person was not able to participate in a scheduled group and/or represented a stakeholder group that was not adequately represented at the focus groups. The (nine) 9 individuals interviewed included:

Doug Ziedonis, MD (UMDNJ –Behavioral HealthCare)
Drew Harris, DPM, MPH (UMDNJ School of Public Health)
Margaret Knight (NJ Office of Cancer Control)
Keith Winnick (Prudential)
Laura Khan, MD (Princeton Univ)
George DiFerdinando, MD (PRONJ)
James Purvis (Quitline)
Kay Paine (Quitnet)
Michael Seserman (American Cancer Society)

It should be noted that the information collected and reported is not meant to be statistically significant. The list of people involved was not a random sample, individuals self selected to participate. The results show perceptions and trends but will not necessarily represent the perceptions/trends of those not participating. In some instances, individuals chose not to respond to certain questions so total number of participants will not necessarily match the number of responses. No response was not assumed to indicate an "*I don't know*" answer. Any decisions made based on the information contained in this report will necessarily need to take into account the targeted interests of those involved.

Special attention was paid to ensuring confidentiality of individual responses in order to create an environment for open and honest input. *CTCP* staff was not present during the focus group discussions and summary notes do not link statements to any individual. Interview data has also been summarized in the report without linking statements to individuals. Interview notes are being kept by the consultant and are not part of the final record given to *CTCP*.

Information Solicited

A standard questionnaire was used for both the focus groups and interviews. This report has been compiled based on these questions (see individual sections for question wording). All participants received a copy of the questionnaire prior to the focus group or interview. They also received a staff prepared list of *CTCP* strengths, weaknesses and future opportunities/threats. This list was the result of a two day staff retreat from December 2004. Addition information provided to participants was a one page overview of *CTCP* programs and services. No other data or reports were shared with any of the groups or individuals.

Any program specific questions raised during the focus groups or interviews were deferred to the end of the process. From time to time focus group participants answered each other's questions about existing data or program services. Special care was taken to not providing specific information which might have changed an individual's response. "I don't know" was viewed and noted as a legitimate and important response to any of the questions. The scan process elicits information about both perceptions and gaps in information. The gaps are typically an important source of strategic decision making.

Use of Data

The data was collected and compiled by The Leadership Group in Trenton, NJ under contract with the NJ Department of Health & Senior Services, Comprehensive Tobacco Control Program. It has been the stated intent of *CTCP* to use the information collected here as input for a three year strategic plan. The plan will impact on future programming and funding priorities for *CTCP*.

Overall Summary

The questions used were designed to elicit responses from different perspectives. Several themes came up repeatedly in response to different questions and they deserve to be noted. This does not minimize the importance of any detailed or single response (see overall responses by question in the last section). The following items came up repeatedly:

1. Integration

a. The "comprehensive" approach taken by *CTCP* could be considered both a strength and a weakness. There was a general acceptance that "one size fits all" should not be a priority strategy for *CTCP*. On the other hand, the wide range of strategies impacts on the ability of individuals to see the whole and appears to support the creation of "silos". Future efforts aimed at service integration and unity of efforts appears important.

b. New and/or increased partnering was a common theme though focused on different issues. The following areas were commonly mentioned as partnership opportunities:
- Increased partnership among current providers and with *CTCP*
  o This is currently viewed as an overly competitive environment which does not serve the best interests of the whole system and those needing service
- Proactive partnerships with the business community and insurers
- Funding and research partnerships with colleges, universities and hospitals
- Partnerships with current local providers who are not currently funded by *CTCP* but are doing work in the field
  o The emphasis here is integration of their efforts into the "comprehensive" system

2. Customizing Strategies for Hard To Reach/Target Populations

a. Future efforts will require new, specialized strategies for the harder to reach and harder to motivate populations. There is a dual focus on new strategies for outreach and new strategies for treatment. It is common perception that *CTCP* has had limited success in reaching and serving:
- Those with mental health challenges
- Those who are addicted to drugs and/or alcohol
- Pregnant women
- Individuals with chronic medical conditions
- College aged students
- The urban population
- Individuals not located near Quit Centers (for some this is a transportation issue for others it is a lower motivation issue)

b. The tobacco industry's strong focus on the 18-24 year old population in terms of incentives and advertising needs a commensurate response from *CTCP*.

3. Health Insurance Coverage for Empowering Medical Interventions

The general lack of health insurance coverage for treatment, except for the Medicare population, is seen as a major obstacle both in terms of service and in terms of motivating health care professionals to make intervention a significant priority.

4. Changing Norms – Impact of Clean Indoor Air Legislation

Community norms have shifted appreciably and have created a significant opportunity for passage of the Clean Indoor Air Bill. There was very strong consensus that the time is right, should not be squandered and that passage will have a critical impact on future *CTCP* priorities. There was a very strong sense that *CTCP* should position itself soon to take advantage of this opportunity by: increasing treatment options, partnering with the business community, advocating for insurance coverage and switching from a predominately educational focus to more of an environmental/enforcement focus.

5. Uses of Professional Evaluation

a. The need for professional, research-based evaluation was noted repeatedly across stakeholder groups. There is a sense that this should be a major future initiative for CTCP which will involve creative partnering and more standardization of efforts. A caution here is the equally strong message that strategies need to be customized to meet special needs/local community needs and over standardization could reduce efficacy for some groups.

> Evaluation data was seen as important for:
> - Bringing credibility for funding
> - Motivating individuals/businesses/insurers
> - Creating a positive message about changed behaviors/norms to balance the negative messages about dangers
> - Dealing with future funding decisions both in terms of growth and reduction

b. The past and future funding situation engendered serious debate. There was considerable consensus that base services are now at risk and that finding funding efficiencies are seriously diminished. Repeated concern was voiced that NJ is dropping too far below CDC recommended levels and that settlement dollars were diverted to other uses. The handling of future funding cuts or limitations did not get a common response. Increased need for treatment services after passage of the Clean Indoor Air bill and for special populations will compete with the need to ensure a base set of comprehensive strategies statewide (treatment, prevention and enforcement) . There was some consensus that future funding decisions must take into account whether there is sufficient data on whether any particular strategy "works".

6. Use of Media

Past and future media efforts received considerable attention in all groups though there was a distinct split on whether it has been or could be cost effective in the diverse New Jersey media markets. Specific concerns came up about underexposure (South Jersey and special populations), lack of a consistent message and lack of follow through on promising campaigns. The recent "Quit To Win" campaign content was uniformly praised but there was a concern that it has dropped from sight.

The following section highlights specific strong trends within each stakeholder group. Issues which crossed over groups are in the summary section above and will not necessarily be repeated here for each group, though they may be noted as a special emphasis for a particular group (i.e.-insurance coverage for the medical professionals).

Current & Potential Providers

This group made up the largest number of respondents (61 out of a total of 98). Participants included local and statewide nonprofits, county based prevention agencies (covering CAT & Rebel services), local health departments, hospital and community based treatment providers, and media, research and publishing professionals. Approximately 20% of participants are not currently funded by CTCP.

Concerns specific to this group included:

- Special needs populations
  Focus was on new strategies needed for the most vulnerable populations

- Staff and leadership changes at CTCP
  Concern for need for continuity and specialized expertise

- Contracting issues
  Main area of concern was late notice or changes in contract requirements, lack of multi-year funding and impact of repeated funding cuts (at what level does funding become inefficient?)

- Funding trends
  Often noted was the loss of settlement dollars to the state treasury and reduction in the number of Quit Centers

- Need for service integration
  This included non-funded providers of service wanting to become engaged in the "system" of services and funded providers desire to share information and identify integration opportunities across the prevention, treatment and community education/community involvement fields

- Educational versus environmental interventions
  The discussion here centered on creating an optimal balance of strategies and protecting the "comprehensive" approach

There was also mention of the move nationally and in the field of public health to environmental strategies that focus on changing norms, ordinances and legislation

Medical Professionals

There were 18 participants representing the medical profession including doctors, nurses, a dentist, grant managers, mental health specialists and public health specialists. Both in focus groups and individual interviews they focused on the following topics:

- Insurance coverage as a driving force for the profession

    While the issue of insurance coverage was repeated across groups it had an additional special emphasis for medical professionals. Not only would coverage provide for more treatment for individuals it would also significantly increase the attention of medical professionals in hospitals and private practice. The pressure is on to see more patients and insurance coverage is a major driving force in how much time is allocated to any particular intervention.

- Need for professional research based strategies and evaluation

    The discussion centered on identification of intervention strategies that work best in the field. Getting documentation of the efficacy of interventions can potentially streamline practices and ensure some level of consistency. Areas of note included concurrent use of multiple cessation strategies and optimal intervention points.

- Linkage of smoking to other chronic diseases

    There was repeated mention of the need to link smoking to other chronic diseases and multiply the intervention points. Heart disease and diabetes were most often mentioned as areas where smoking exacerbates the problem and makes treatment more difficult and costly.

- Advocacy issues

    While the need for legislative advocacy surfaced in many groups the medical professionals made special mention of the need to be ready to respond once the Clean Indoor Air bill is passed. Both increased treatment and enforcement was high on their list of priorities responses.

- Partnership opportunities

    There was a strong emphasis in both focus groups and individual interviews on the need for proactive partnering between CTCP and hospitals, universities, research facilities, insurance companies, the pharmaceutical industry and the business community.

Youth (High School and College Age)

There were 18 participants in two focus groups with one targeted to high school students and the other with college staff. Both groups were active participants and leaders in the statewide REBEL program. It should be noted that while there was overlap between the two groups in terms of concerns there was also a distinct difference in priority issues. It should also be noted that the high school youth group was the most engaged of all focus groups, insisted on remaining past the scheduled time and had full participation of each attendee (everyone had strong opinions about each topic). Special emphasis was placed on:

<u>High School Students</u>
- Youth empowerment issues
    There was strong concern that the emphasis on youth empowerment has shifted away from high school youth and onto college aged youth or adults. Also the move to a Council of Nine has restricted more general and timely access to information, which was seen as disempowering.

- Particular norms impacting on youth
    Issues of peer acceptance, weight control and a growing division between those who smoke and those who do not were major concerns. It was felt that youth smokers were starting to get alienated by the Rebel movement and an uncomfortable us/them situation was being created.

- Accountability
    The youth spoke passionately about the need to hold Rebel groups accountable for their actions and use of funds. There was additional concern about the wide range of skill level and dedication of the professional youth advisors. This position was felt critical to local youth involvement but a high turnover rate and differing standards leave some areas with fewer options.

- Enforcement
    Though mentioned by many groups, the youth were most specific about the continued availability of tobacco products. They specifically mentioned increase use of "loosies", flavored cigarettes and easy access to tobacco products.
    There was also repeated mention that school no smoking policies are being ignored by students and school staff.

<u>College Staff/Educators</u>
- Particular norms impacting on college students
    The link between smoking and drinking for college students was addressed. It was also noted that smoking is considered an introductory drug/addiction for college aged youth. The targeted marketing by tobacco companies to this age group is using these opportunities to engage students.
    There was considerable discussion of specific attitudes and beliefs for this age group that require different interventions. A sense of invincibility, an increased sensitivity to issues of individual rights and a belief that they can control their smoking behavior (and therefore decrease the damage) all point to a decreased

emphasis on harm reduction and a need to find a new "hook" relevant to students.
- Impact of smoke free legislation
    Passage of smoke free dorm legislation was seen as a positive step but there was concern about readiness of the system to respond to the resulting need for education and cessation programs. There was also a concern about what new addictive behavior would increase as a result.

Business Community

This group was seriously under represented in the sample. Numerous attempts to engage the business community including targeted mailings to those currently involved in programming, and phone calls to encourage participation. This extra effort only resulted in one phone interview with a human resource professional at Prudential.

While in no way representative of the business community in general, his special emphasis was on reducing health care costs and the need for more workplace cessation programs.

Responses included here cover both those that were repeatedly mentioned and those that were mentioned by only one person (or a few) but were presented as cutting edge, research based or based on national best practices.

Mission & Goals
Question: "How would you describe your perception of the current mission and goals of CTCP?"

There appears to be a lack of a unified understanding about the mission and goals of CTCP. It was clear that the mission of *CTCP* was either viewed as a particular piece (get people to stop) or a larger comprehensive system (*interlocking system of prevention, enforcement and treatment). Most respondents first mentioned individual pieces; a vocal minority (across all target groups) stressed the system itself as primary.

The following items were listed most commonly as the priority mission of *CTCP*:
- Decrease # of smokers in NJ
- Decrease exposure to environmental smoke
- Prevent new smokers from starting, especially youth
- Change community/society norms about smoking
- Advocate for and enforce tobacco related legislation and regulations (to accomplish above)
- Provide data, materials and training
- A comprehensive, multi-layered approach to the above*

One summary of the mission was stated as:
"Less people start smoking at all and those who already smoke have the resources to quit"

Those most likely to answer "*I don't know*":
- Hospital and medical center personnel who do not currently get funding
- Community based providers who are not now or have not recently received funding

Current & Future Trends To Keep on Radar Screen
Question: "What are the trends in your community/field that you want to make sure CTCP includes as a priority in their planning for the future?"

The range of responses fell into the following categories:

Regarding Treatment Services
-NJ has already reached the easier to serve/ the motivated quitter and are now coming to the more difficult cases that are both harder to reach and harder to serve:
- People are not motivated enough to travel far for cessation services

- The remaining smokers seem sicker medically overall
  - They have chronic disease exacerbated by smoking (heart, diabetes, HIV)
  - The treatment of chronic disease costs more for smokers
- Traditional strategies not working as well with harder to reach, harder to serve groups especially:
  - The mental health population
  - Those addicted to drug/alcohol (these first 2 groups consume 44% of all cigarettes sold)
  - Pregnant women (high motivation but strategies not working as well)
- Only 15-30% of insurance companies currently cover treatment and then only minimally
  - Drug stores reluctant/unsure how to honor Medicaid reimbursement (prescription) for OTC patch
  - We should advocate the Medicare model for coverage of treatment with other insurers
- Recent national health focus on <u>obesity</u> may start to backfire for smoking cessation and prevention efforts, especially for young girls who use cigarettes for weight control
- Recent events (death of Peter Jennings, Dana Reeves representing higher incidence of female non-smokers with lung cancer) have had strong media exposure and are opportunities for reaching new markets
- People are increasingly comfortable using the web as a primary resource
  - While web based strategies will not be the sole answer, it does act as an important portal for individuals to connect with community based resources
- The use of multiple strategies concurrently (rather than sequentially) is becoming more common in the field
  - There is some research that this use of multiple strategies is also more effective

<u>Regarding Community Norms</u>
- There is a noticeable increase in smoke free locations (malls, hospitals, college dorms, restaurants etc) that voluntarily made this decision before any legislation is enacted
- Schools continue to not enforce smoking policies both with students and staff
- Residential and outpatient treatment programs for Mental Health issues and Addictions still routinely have smoke breaks for clients
  - The professional culture about encouraging quitting has shifted, but only slightly
- Now is the time to pass the Clean Indoor Air bill since the norms have shifted appreciably in NJ (and smoking is down) and there is willing political leadership to make it happen
- The relationship between drinking and smoking is especially pronounced for college students
- Need to identify the right balance between issues of individual rights and public health

- o The individual rights issue currently resonates more with college students than the public health dangers

Regarding Enforcement
Higher cigarette prices and slowed down enforcement may be contributing to:
- ▪ Prevalence of "loosies" available especially to the most vulnerable populations
- ▪ Easier access (in aisle) to other tobacco products (and therefore increased use by youth)
- ▪ Increased online sales

Regarding Medical Community Response
- ▪ OB/GYN's (prenatal clinics) are more on board than most other doctors
  - o This effort has been a success that should be repeated with others medical professionals
- ▪ Doctors seem unaware of research that says they can use several treatment modalities concurrently
- ▪ Dentists do not have this on their radar screen at all
- ▪ JCHO requirements include smoking habits on all medical assessments
  - o We now have the info but what do we do with it? (And how do we hold the system accountable?)
- ▪ Hospitals and doctors will fall in line with those items covered by insurance
  - o Lack of coverage means this topic does not get priority focus
  - o There is increasing pressure to decrease costs and see more patients
- ▪ Doctors need quick interventions that have been proven to work

Regarding Marketing
- ▪ The tobacco industry is focusing on 18-24 years old (whether or not in college) and is hiring people to hand out free cigarettes on campuses and urban street corners
- ▪ Financial incentives to smoke (coupons etc.) still exceed perceived financial incentive to quit
- ▪ Other states have made significant investments in "creatives" for new ad campaigns. NJ could possibly purchase the rights to use these at a significantly lower cost

Regarding Data & Evaluation
- ▪ The North American Consortium is working on standardization of data points and best practices into an online database
  - o These will soon be available for benchmarking purposes
- ▪ Future funding will depend on evaluation data to justify the investment
  - o Strong evaluation data and use of evidence based strategies can provide credibility to funding requests

Reaction to Staff SWOT Analysis
Question: "Attached is a draft list of *CTCP*'s strengths, weaknesses, opportunities and threats. Please choose one from each section that you consider the most important to address in the next 3 years."

Please note that participants chose one top priority from the existing list created by *CTCP*. Percentages are relative to each other and do not necessarily indicate that lower percentage items have no or little priority. The question was posed as: "*If you could only have one, which would you choose?*" not "*Is each item a priority for you?*"

Major Strengths of *CTCP* (across all groups)

Major indicators point to decreases in smoking for most population groups	24%
Merchant compliance with not selling to minors has steadily increased and is above target rates	14%
Smoking norms are changing	**62%**

The most common items to be added to strengths include:
- NJ use of innovative approaches including treatment plan with multiple modalities, middle school to college youth initiative
- Multi-layered approach with strong diversity of providers
- Statewide consistent approaches (i.e.: infrastructure built by CATS)
- Youth involvement in enforcement

Major Weaknesses of *CTCP*

Lack of a common/integrated identity for *CTCP* efforts	15%
Lack of clear service specific evaluation data	10%
Financial instability and funding reductions	**62%**
Lack of adequate program infrastructure for contract monitoring, media/marketing, training and data collection / analysis	12%

The most common items to be added to weaknesses include:
- Lack of sense of community among providers (actually a sense of competitiveness has been fostered by the *CTCP*)
- CTCP allowed settlement dollars to be diverted to other uses without a reaction or getting something out of the loss
- Loss of funding for NRTs
- Media efforts
  - Do not need "new" campaign every year
  - Not enough of any one campaign to see how well it worked
- Not maximizing use of existing resources and expertise in NJ

Major Future Opportunities or Threats for *CTCP*

Opportunity for increasing / sharing revenue from fees and fines	15%
Need to automate functions for reporting and data collection to reduce paperwork and increase efficiency	4%
Norms have changed but increased enforcement is still needed, especially for school no-smoking policies and changes to mandatory local investigations	20%
Need and opportunity to implement Smoke Free NJ/Clean Indoor Air through legislation comparable to other states	**61%**

Future Services:

Question: "As you consider the next 3 years, what would you want *CTCP* to:
- **a. Continue doing?**
- **b. Stop doing?**
- **c. Start doing?"**

Continue:
- Treatment, especially if Clean Indoor Air bill passes
- The comprehensive, balanced approach to prevention, enforcement and treatment while prioritizing those activities in each that can prove they "work"
- Youth led/youth empowered programming
- Public pressure to change norms
- Subsidized NRTs
- Generating reports on usage patterns in youth and adults
- Media presence (though cheaper)

Stop:
- Changing the rules/changing the people
- Mailings to physicians (they are routinely discarded)
- Primary focus on a health education approach
  - Need to increase focus on the environmental interventions
- The legislative focus on smoke free cars (makes us look foolish and too far ahead of community)
  - Keep the focus on the Clean Indoor Air Bill as the primary goal
- Counting volume only (youth)
- Moving power to adults (youth)
- Focusing primarily on youth users rather than the industry and community norms
  - Youth are not responding to focus on the dangers of smoking
  - Focus on the youth user also creates an us (nonsmokers) versus them (smokers) conflict that reduces the ability to engage the smokers

<u>Start:</u>

- A *CTCP* Advisory Group or independent Board to provide on-going input and advocacy
- More intentional linkage and collaboration with local providers, researchers, universities, other state Dept.'s, public health etc. for:
  - Joint research/grant opportunities
  - Regular opportunities for input/sharing of expertise
  - To identify integration opportunities across treatment, prevention and enforcement
  - Opportunities for advocacy
- Pulling together insurance companies, businesses (who purchase insurance) and pharmaceutical companies to advocate for reimbursement for treatment (would mean savings to *CTCP*)
  - State health plan should be the model plan and it is not (Does the State really mean it if it does not require state plan to cover?)
  - Provide tools for employees and employers for education and treatment, especially once Clean Indoor Air legislation passes
  - Be proactive and don't wait for businesses to come to *CTCP*
- Identification of new strategies for outreach and treatment for special needs populations
- Encouraging and supporting existing local cessation programs (perhaps mini-grants to those already running them in local health dept. and hospitals and outpatient facilities)
- Being more assertive on facilitating support for new Clean Indoor Air bill
  - *CTCP* will also need to be ready once the bill is passed since there will be potential for a sudden increase in demand for treatment (beyond current system capability)
- Doing real, professional evaluation research including evaluating current services and identifying new strategies that might be more effective in the future
  - Better define the desired outcomes
  - Start keeping list of best practices in field for all to use/review
  - Connect desired social norms to program data/results
  - Emphasize the link between a decrease in smoking to positive health results (not just the usual negative data)

Success To Date

Question: "How would you rate the success to date of the *CTCP* on a scale of 1-10 with 10 being the highest?" What criteria did you use to choose a response?

Score	#of Respondents	% of Respondents
1	1	1%
2	2	2%
3	3	3%
4	7	8%

5	**17**	**19%**
6	**23**	**26%**
7	**18**	**20%**
8	7	8%
9	1	1%
DK	9	10%
Total	88	100%

Criteria for Scores:
- Those below 5 typically focused on the amount of work that still needs to get done and that their own lack of knowledge about *CTCP*
- Those above 5 focused on decreases in youth smoking and general indicators
  - They typically reported feeling that the program has come a long way, against the odds
  - They mention comparisons to other states especially in terms of creativity and innovation

Future Competing Priorities of Stakeholders
Question: "What are your top professional priorities for the next 3 years? (That might compete for time and resources)"

Responses here differed by target group:

Providers:
- Financial sustainability (meeting cost increases outside their control)
- Staff turnover and retraining (especially in youth programs)
- Determining when a project is cost effective to run
  - Identification of where efficiencies are possible and effective or where there are no efficiencies left and we are cutting the core service
- Integration of services across providers

Local Health Officers/Public Health/Medical:
- Bio-terrorism
- Needle exchange
- Obesity
- Colon Rectal screening
- Address chronic disease and Healthy People 2010 Goals (i.e.: reduce cardio vascular disease by 25% by 2010)
- Healthcare quality, safety and cost
- Pressure for scientifically rigorous evaluation in all programs
- Follow lead of insurance companies on what they are willing to reimburse
- Create NJ specific Journal for Public Health

Youth Related:

- Graduation or transition of peer group
- Addressing Alcohol issues
- Reducing STD's
- Addressing trends in Mental Health and Drug Abuse

Corporate: (1 response)
- Decrease health care costs